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**INDIVIDUAL HEALTH READINESS – A LEADERSHIP
RESPONSIBILITY**

BY

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USAWC Strategy Research Project

Individual Health Readiness - A Leadership Responsibility

by

LTC Joan M.G. Lyon

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ABSTRACT

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During the 21st Century, the continual evolution of advanced weapons systems combined with a smaller Army force structure will increase each soldier's importance. This creates a mandate to enhance individual soldier readiness. Army leaders must learn to provide a comprehensive program to promote individual readiness through soldier preventive maintenance (Soldier PM). Leaders must be trained to create, monitor and sustain environments that value and promote health. Leaders must incorporate Soldier PM into every level of military training, making it as much an intrinsic Army standard as is preventive equipment maintenance.

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Individual Health Readiness - A Leadership Responsibility

Joint Vision 2010 projects a dramatic increase in the complexity of future warfare as a consequence of advancing technologies and spatial expansion of the battlefield. This will heighten battle dynamics, requiring commanders and their soldiers to make split-second decisions. At the tactical level, each soldier's role will increase due to technology integration, and improved weapons lethality and precision. The accelerated "tempo of action – reaction – counter-reaction" will push battle decision authority further down the Chain of Command thereby expanding each soldier's autonomy.¹ All three elements of readiness - force, unit and individual - must continue to increase to ensure effective and responsible deployment of these new, advancing technologies.

The idea that health impacts individual readiness is common sense. Much has been done to increase individual readiness, including new focus areas during formal military schooling, joint readiness training exercises, and Army family preparedness programs. The challenge is to find additional methods for improving average performers. Today's Army needs leaders who recognize that it is their responsibility to promote health readiness by creating work environments that make health a high priority.

This paper proposes the establishment of a Soldier Preventive Maintenance (Soldier PM) Program, the human equivalent of weapon system maintenance plans. Soldier PM, a facet of Force Health Protection (FHP), is a critical component of readiness. This paper will describe the genesis of Force Health Protection, identify major FHP initiatives, and provide examples of the impact of health upon performance. It will also discuss the leader's responsibility to motivate

soldiers to be healthy in order to optimize their performance, and highlight approaches for implementing the Soldier PM Program.

Background

In the current era of declining military budgets, it is difficult for Army leaders to find the point of equilibrium that maintains current readiness and embraces force modernization. Indeed, readiness is difficult to quantify, particularly as a measure of the functional status of individual soldiers.

Individual readiness is a reflection of each soldier's state of training and his physical, intellectual, and emotional ability to perform the mission.²⁻⁴ It is the cornerstone of unit⁵ and force⁶ readiness. The continual evolution of advanced weapons systems and our smaller force structure puts ever-increasing pressure on individual readiness. Consequently, the Army leadership challenge is enhancing individual soldier readiness and performance. General Shalikashvili, Chairman of the Joint Chiefs of Staff from 1993 to 1997, stated, "No matter how sophisticated technology becomes, the individual warfighter's judgment, creativity, and adaptability in the face of highly dynamic situations will be essential to the success of future joint operations."⁷ Joint Vision 2010 identifies the soldier as the most critical component of the high-tech battlefield. The criticality of the soldier was identified again in the most recent Army Posture Statement to the 106th Congress. "Quality people are the first of the six imperatives and the single most important factor for maintaining readiness. The Army is people. Army capabilities to shape, to respond, and to prepare are embedded in the foundation our people provide... It is the people who do the unexpected, extraordinary things in difficult circumstances who make the Army much more than the sum of its parts."⁸

Instructions for Commandant of a Regiment:

"The preservation of the soldier's health should be his first and greatest care; and as that depends in great measure on their cleanliness and manner of living, he must have a watchful eye over the officers of companies that they pay the necessary attention to their men in those respects."

*Frederick William Von Steuben
Inspector General
Regulations for the Order and Discipline of the Troops of the United States
Valley Forge, Pennsylvania 1778-1779*

Military leaders have long known that their soldiers' wellness is essential for optimal readiness. In weapons systems, readiness is achieved through deliberate planning and preventive maintenance. All major weapons systems and military equipment have detailed acquisition and maintenance plans across their lifecycle.⁹⁻¹¹ Throughout their careers, leaders receive formal training on directing the acquisition, employment and maintenance of this equipment.^{12,13} Similarly, life-cycle maintenance plans for soldiers would help them achieve optimal functional status. According to modern warfighting concepts, the soldier is our most sophisticated weapon system. Because each soldier's impact within the force will continue to increase, leaders must provide a comprehensive Soldier PM program. The program goal will be optimal fitness for duty to ensure the most effective employment of their advanced warfighting technologies. In order to achieve this goal, leaders will have to receive training throughout their careers on directing and managing soldier maintenance/wellness.

The Genesis of Force Health Protection

On November 8, 1997, President William J. Clinton issued Presidential Review Directive 5 (PRD-5) stating, "Every soldier, sailor, airman, and marine will have a comprehensive, life-long medical record of all illnesses and injuries they suffer, the care and inoculations they receive, and their exposure to different hazards. These records will help us prevent illness and identify and cure those that occur."¹⁴ With PRD-5, President Clinton charged the Department of Defense to apply lessons learned from the Gulf War, Somalia and other recent military actions to future troop deployments.

PRD-5 is about the military's accountability to America's servicemen and veterans. Conceptually, PRD-5 addresses the view that a soldier's health readiness or wellness while on active duty impacts mission accomplishment. It also implies that military leaders have failed to take responsibility for active duty soldiers' wellness, and for duty-related consequences that arise afterward. Clearly, certain elements of PRD-5 are already implemented across the Armed Forces and other initiatives, such as anthrax immunization and tracking, are underway. Why is it still necessary to address the issue in this paper?

In conducting the research for this paper, the author interviewed a broad spectrum of military leaders and was surprised to find a common attitude – dismissal of the line leader's personal responsibility for troop health readiness by identifying it as a medical problem and an individual responsibility. The question that arose was, "Are these attitudes a reflection of the training that leaders receive?" Evaluation of doctrine and training materials revealed a different, perspective about preventive maintenance for soldiers as compared to doctrine and training materials for preventive maintenance of equipment. It transcends the obvious difference that

weapons systems and equipment are inanimate while soldiers are human. The differences are evident in the value statements and language used in training materials and can be seen by reading the initial motivational statements in the Common Core Course Training Support Packages used in Army leadership training programs. Course materials for weapons system/equipment maintenance emphatically state the leader's responsibility for prevention and maintenance to ensure readiness.¹⁵⁻¹⁷ In contrast, the course materials for soldier maintenance address the importance of the topic, but the leader's role is left unstated.¹⁸⁻²⁰

Force Health Protection (FHP) is the military health strategy that addresses the objectives set forth in PRD-5, supports Joint Vision 2010 and will evolve to support the Army After Next. Conceptually, FHP consists of three pillars:

- ◆ *Promote and sustain wellness to ensure deployment of a fit and healthy military force.*
- ◆ *Implement medical countermeasures to prevent casualties from occurring in the deployed environment.*
- ◆ *Provide high quality casualty care.*²¹

The third pillar of FHP addresses the mission of returning casualties to health and is beyond the scope of this paper.

In many ways, the Military Health System's approaches designed to meet FHP goals parallel the trends in civilian health care. "Whenever we put an American pair of boots in the field, we need to fill those boots with somebody who is healthy and fit to do that particular job. That means a combination of training, good health surveillance, vaccinations and good health habits. And that guy has to be socially and psychologically fit as well," stated Admiral Cowan, Director of Joint Staff Medical Readiness.²² As the FHP planner on the Joint Staff, Admiral Cowan, his staff and other medical and line planners throughout DoD, are changing medical

doctrine. The changes are not revolutionary, but evolutionary -- reflecting advances in evidence-based medical science and outcomes-based approaches for maintaining health. In the past, the focus of military and U.S. medicine was curing disease. Today, health care providers recognize the importance of preventing disease. In the military context, that means enhancing battle effectiveness by deploying healthy, fit soldiers who are better able to resist non-combat disease, environmental hazards and injuries.²³

To accomplish FHP initiatives, roles and responsibilities must extend well beyond the command and control of the Military Health System. In January 1999, Secretary of Defense William Cohen chartered the DoD Prevention, Safety and Health Promotion Council (PSHPC). This executive council is charged with tackling issues associated with the first two pillars of FHP: "Promote and sustain wellness" and "Implement medical countermeasures to prevent casualties." Responsibilities in the Council's charter include:

- ◆ *"Recommend uniform, comprehensive, health and safety promotion and injury/illness prevention policies and programs,*
- ◆ *Engage medical, line, and community leaders and organizations to create and strengthen a health-promoting culture across the DOD.*
- ◆ *Seek ways to engage DoD personnel, family members, retirees, and civilian employees on their co-responsibility for their health, fitness, and wellness.*
- ◆ *Ensure successful deployment of "Put Prevention into Practice" (PPIP) and related programs.*
- ◆ *Recommend methods to ensure the successful deployment of the Health Enrollment Assessment Review (HEAR).*

- ◆ *Seek research for improvement of human performance, health and safety education, standards/procedures, and personal protective and monitoring equipment.*
- ◆ *Ensure effective, DOD system-wide communication of all approved health promotion and injury/illness prevention policies and implementation instructions.*
- ◆ *Promote Operational Risk Management as a means of improving mission success and preserving human and physical resources throughout the DoD.”*²⁴

Force Health Protection and the Army Functional Life Cycle Model

Force Health Protection fits logically within the Army Functional Life Cycle Model (AFLCM). The model details the system required to produce the right combination of trained soldiers and mission-ready equipment at the right time.²⁵ The model portrays a system that cycles in a dynamic continuum and includes force development, acquisition, training, distribution, deployment, sustainment, development and, ultimately, separation. Two external factors are resources and command/management/leadership. FHP is a component of each process in the AFLCM and is critical for ensuring that individual soldiers are optimally ready to perform their missions.

Optimum Health Is Essential For Maximum Performance

The demands imposed upon soldiers during military operations are profound. “Even during the first night of combat, or a field exercise, normal sleeping habits and routines are upset. The soldier feels the effects of fatigue and the pressure of stress from noise, disrupted sleep time

and threat to life.”²⁶ Mission success requires optimal performance from each individual -- physical, mental and spiritual. It was 200 years ago that Von Steuben wrote that the Commander’s greatest responsibility is the preservation of his soldiers’ health. Our health knowledge has grown exponentially since that time. Science and technology have helped us to better define health and to understand the health risks associated with lifestyle choices and behaviors.

Health is a state of complete physical, mental and spiritual/moral well being, not merely the absence of disease or infirmity.²⁷ It imparts the ability to perform daily activity with vigor. The physical, mental and spiritual aspects of health are inextricably linked. Positive changes in one aspect generally result in positive changes in the other aspects. The same applies for negative changes. In 1994, the International Consensus Conference on Physical Activity, Fitness and Health defined fitness as “matching of the individual to his physical and social environment.” Outcomes associated with fitness are increased performance and health.⁴ Performance related components include agility, balance, coordination, mental acuity, speed, power and reaction time.²⁸

Optimal mental health gives one the ability to negotiate the daily challenges and social interactions of life without experiencing cognitive, emotional or behavioral dysfunction. It can be affected by numerous factors ranging from biologic and genetic vulnerabilities, acute or chronic dysfunction, to environmental conditions and stresses. Critical life events, chronic role strain, the accumulation of life hassles and environmental pressures such as urban overcrowding, long commutes, or job workloads are conditions can build and eventually exceed an individual’s ability to cope.²⁹ Research conducted during military deployments during the last decade shows that all types of operations, whether combat, peacekeeping, humanitarian, or domestic

crisis support, create stress. "Responsibility for the management of soldier's stress lies with command – with the support of the chaplaincy and military mental health professionals." ³⁰ During military operations, factors such as strong leadership, unit identification, motivation and validation ³¹ significantly reduce stress casualties. ²⁶

Mental and spiritual/moral health are closely intertwined. For many people, spirituality is a facet of mental health. The distinction is that mental health deals more with a person's ability to cope with the surrounding world, while spiritual/moral health has more to do with having an intrinsic sense of meaning in life. Personal ethics, beliefs and goals, positive family dynamics, internal motivation and trust provide a source of inner strength in difficult or stressful times. Optimal effectiveness requires that soldiers be personally and professionally committed to their mission. ³² In spiritual/moral terms – they must have a motive for action and faith in commander's ability to lead them to success and survival. ³⁰

Physical health is determined by an individual's level of conditioning, nutritional status, motivation, genetics, and resistance to disease and injury. ³³ With the exception of genetics, all of these elements can amplify one another. ^{4,34} For example, physical training enhances performance, improves health, and increases resistance to disease and injury.

Both short- and long-term health-related behaviors impact soldier readiness. Examples of short-term specific behaviors that significantly impact readiness include:

Nutrition. During prolonged endurance activities, soldiers must increase their caloric intake, especially from carbohydrate foods, in order to meet their energy demands. Failure to do so contributes to chronic muscle fatigue, a feeling of staleness, weight loss and poor sleep patterns. There is evidence that some accidents judged to involve aviator fatigue were related to irregular eating

patterns and skipped meals.²⁶ Once glycogen stores are exhausted, performance decreases sharply. Liver and muscle glycogen are the primary source of glucose for muscles during prolonged endurance activities. Therefore, the key to optimal endurance performance lies in maintaining muscle and liver glycogen stores through proper nutrition.³⁵

Sleep. Military effectiveness increasingly depends upon high-order, complex mental operations at all levels of command and control. Sleep deprivation leads to neurobiological changes that impair complex mental functioning such as situational battlefield awareness, adaptability, mental agility, initiative and anticipation. Sleep deprivation contributed to friendly fire incidents in Operation DESERT STORM. Obtaining adequate sleep is crucial for sustaining performance.³⁶

An example of a longer-term behavior with significant negative impact upon soldier fitness and performance is:

Smoking. The acute negative impact of smoking, airway resistance, is evident with as little as 15 puffs on a cigarette during a five-minute period. Chronic cigarette smokers tend to be less physically active and have lower levels of fitness than their non-smoking counterparts. Although the mechanism is not understood, cigarette smoking increases the smoker's dependence on carbohydrates for energy at rest and during sustained exercise.^{37,38} Other consequences of smoking

that impair military readiness include decreased stamina, decreased night vision, decreased hand-eye coordination, increased risk of developing cold weather injuries and overall injuries, and decreased wound healing. ³⁹

As the sophistication of military equipment increases, there will be increased demands in terms of human performance. It is difficult to predict which components of performance and which aspects of health will be most important during the various stages of an individual soldier's career. Therefore, it is most effective to focus on optimizing all facets of health – physical, mental and spiritual – through a Soldier PM program.

Worksite Health Promotion in the Active Duty Military Setting

The associations between lifestyle behaviors, the work environment and health, and their potential for enhancing combat readiness has military importance. In recent years, the Army has increased its health promotion efforts to enhance military readiness. Unfortunately, the prevalence of cigarette smoking, alcohol abuse, and other poor health practices of Army personnel continues to be high.⁴⁰ Data suggests that simply enforcing the Army Physical Fitness Test (APFT) has not achieved an improvement in the overall fitness of military troops. In 1995, the Army Fitness School conducted a survey of Army personnel fitness using a random sample of 3,000 active duty soldiers stratified by age, gender and military occupational specialty. The results showed a gender disparity in fitness⁴¹ and a high failure rate of younger soldiers.⁴² Reasons cited for the high failure rate included inadequate motivation and training. The study concluded that renewed emphasis on physical conditioning, especially of younger soldiers, was necessary.⁴ The health promotion behaviors of military personnel can be improved. One study found that soldiers who participated in more exercise, improved their diets, and increased their hours of sleep were less likely to smoke.⁴³ Other obvious issues for health promotion are alcohol abuse, drug use, and mental wellness. Creating health-promoting organizations and Army leaders who are role models are critical strategies for targeting these issues.

A growing body of scientific evidence links lifestyle behaviors and the work environment with health. Many people adopt healthy lifestyles in an effort to avoid disease and illness. But health-promoting behaviors do more than prevent illness and injury. They lead to improved performance, greater fulfillment, a higher quality of life, and ultimately, to global well being.⁴⁴ Factors such as demographics, motivation, interpersonal dynamics, and current personal situations determine whether an individual does or does not practice health-promoting behaviors.

The demographic factors identified as most influential toward adopting health-promoting behaviors include age, gender, education and income levels, and professional/nonprofessional work role definitions.

Social networks play a significant role in a person's beliefs and values regarding health-promoting behaviors. Social influences can positively enhance or negatively inhibit health-promoting behaviors.⁴⁴ One study found that 28% of the variance in practicing health-promoting behaviors could be attributed to a combination of social support and self-esteem.⁴⁵ Another study reported that subjects practiced healthier behaviors if they were motivated to maintain a high level of perceived health status and believed that their health was influenced to some extent by others through interpersonal relationships.⁴⁶ The social support of coworkers has been demonstrated as a positive force for long-term smoking abstinence and relapse prevention. Similarly, group participation has been associated with improved exercise adherence and weight control. The impact of the work environment must not be underestimated with regard to the adoption of health-promoting behaviors. An environment that encourages and supports health behaviors and the influence of coworkers are the two factors that are most important for improving health promoting behaviors in the workplace.^{40,47} In the civilian sector, the focus of worksite health is shifting away from individually oriented wellness programs toward broader concepts that emphasize the joint impact of the physical and social work environment, work policies and job-person fit.^{44,47} Similarly, Military Health System leaders have recognized that in order to make FHP a success, it is imperative that Army leaders create health-promoting organizations.

Worksite Health Promotion in the Reserve Military Setting

Reductions in the active force have made the reserve component even more essential to meeting the Nation's needs across the full spectrum of operations. Reserve forces comprise 55% of the Army. The Reserve Components (the Army National Guard and the Army Reserve) are partners with the active force in meeting the challenges of the 21st Century, and must be equipped, trained and maintained to perform assigned missions.⁴⁸

Reserve Component (RC) personnel live in two worlds - civilian and military. Army Reserve and National Guard soldiers must maintain their civilian careers, while continuously preparing physically, mentally, and emotionally for military activation. The majority of reserve personnel spend one weekend per month and two weeks per year on active duty for training. Few studies exist regarding RC soldiers' health behaviors and working environment, and their impact upon military readiness.⁴⁹

Reservists tend to be older than their active duty counterparts. This age difference places them at greater risk for health problems. A recent Army Times article presented statistics regarding Army Reservists' physical fitness. Army Physical Fitness Test failure rates were higher in reservists than in active duty personnel. The article indicated that while some reservists engage in short bursts of physical training and weight loss regimens before the annual physical fitness tests and weigh-ins, many do not have regular physical fitness routines.⁴⁹ The extent of this behavior occurs and its impact on readiness are unknown.

A 1994 study of 560 reservists revealed a level of alcohol abuse estimated at 11.3% and a level of alcohol dependence estimated at 6.6%. A comparison to other cohorts found that alcohol abuse and dependence was higher for reservists than similar civilian cohorts, but lower

than active duty Army samples. Additionally, health promotion data from the U.S. Army Center for Health Promotion and Preventive Medicine reveals that, compared to active duty soldiers, more reservists smoke.⁴⁰ The obvious concern is that health-related behaviors among RC soldiers may impair military readiness.

These unique characteristics of the Army Reserve present challenges in providing health promotion programs similar to those for active duty personnel. Ongoing soldier maintenance programs are infrequent. Reserve programs tend to be reactive -- provided after a failure has occurred. For example, the solution for reservists who fail to meet physical fitness and weight standards is remedial physical training and weight control counseling during weekend duty.⁴⁰

Reserve force readiness is imperative to ensure effectiveness of the total Army force. Creating reserve organizations that value and promote healthy behaviors is an important step toward meeting that imperative.

Ensuring Readiness Through Preventive Maintenance

“If you don’t maintain, you can’t train!”⁵⁰ Preventive maintenance is vital to military training and operations. Equipment, such as tracks, weapons, wheeled vehicles, and radios, must be maintained to ensure that it is mission capable. Everyone - leaders, maintenance personnel, and operators - must be trained and involved to improve and sustain the unit’s maintenance posture.⁵¹ To ensure weapons and vehicle readiness, military units employ the principles of Preventive Maintenance Checks and Services (PMCS). The primary goal of PMCS is early intervention and prevention – detection and repair of minor equipment hazards or failures. “It is impossible to maintain equipment readiness without conducting proper PMCS.”⁵² While individual soldiers conduct PMCS, it is the leader’s responsibility to create the environment that values and enforces maintenance discipline by ensuring that PMCS is performed correctly.⁵⁰ This leadership responsibility extends up the chain of command with each level being accountable to the next. Ultimately, the Army Chief of Staff is accountable to the Secretary of Defense who is accountable to The President and the American people. But, it all starts with PMCS.

Leaders must establish the same environment and values for Soldier PM. Just as PMCS does not end with the individual who performs the service, soldier maintenance is ultimately the line commander’s responsibility. Commanders do not accept preventable degradation in major weapon systems. They should not accept it among our most valuable assets, our soldiers. The first step in establishing Soldier PM is creating an environment that values health and makes it a priority.

Leader Responsibility for Ensuring Optimal Health Readiness

"Commanders must always take advantage of opportunities within their control to enhance readiness."

*The Joint Training System:
A Primer for Senior Leaders, 1998* ⁵³

The final draft of Army Leadership, FM 22-100, dated 10 February 1999, quotes former Sergeant Major of the Army Richard A. Kidd as stating, "Whenever the talk turns to what leaders do, you'll almost certainly hear someone say, Take care of your soldiers. And that's good advice. In fact, if you add one more clause, accomplish the mission and take care of your soldiers, you have guidance for a career. But, taking care of soldiers is one of those slippery phrases, like the word honor, that lots of people talk about but few take the trouble to explain."⁵⁴ A significant part of taking care of soldiers is to ensure that they are ready to accomplish their missions. Creating a health-promoting environment that supports optimum individual readiness is within each Commander's control.

The higher a leader is in an organization, the broader the scope of health readiness issues he must manage. A platoon leader supervises junior enlisted personnel, aged 18-22, whose negative health-related behaviors may range from poor eating habits, inadequate physical activity, smoking, drinking, to unsafe sexual activity. Commanders at company, battalion, or above who supervise the platoon leader and his troops, as well as older soldiers who may be more sedentary and have health risks associated with aging, family and financial stresses. Additional health concerns occur with reserve forces that augment active troops during deployments.

Preventive maintenance is a process of intervention to restore reliability.⁵⁵ Just as aspects of preventive equipment maintenance are incorporated at every level of military training,

so should be the concepts of soldier preventive maintenance. For example during Initial Entry Training, soldiers are taught how to care for their weapons and field equipment; in Basic Non-Commissioned Officer (NCO) training, NCOs are taught supervision of equipment maintenance; and, in the Officer Advanced Course, lieutenants and captains are taught how to establish and direct equipment maintenance for their company/unit.^{16,17,56} Because these maintenance concepts, skills and practices are taught and reinforced throughout each soldier's career, they have become intrinsic Army standards, skills and actions.

The Military Health System monitors and enhances soldiers' health readiness by using the Put Prevention Into Practice (PPIP) program,⁵⁷ which provides a uniform, system-wide, life-cycle approach to preventive services.⁵⁸ The first step is administering the Health Enrollment Assessment Review (HEAR). The HEAR is a self-reported survey designed to establish a soldier's baseline health status and identify lifestyle behaviors that increase health risk. Collectively, HEAR data are used to establish programs to improve and manage population health. In surveys, individuals often deny excessive behaviors. For example, a two-pack-a-day smoker may admit to smoking one pack and a person who drinks a six-pack of beer each day may admit to two or three beers. By creating an environment that places health as a priority, leaders will encourage soldier's to honestly evaluate and improve their personal health behaviors.

Just as preventive maintenance varies according to the specific piece of equipment, soldiers' health promotion/preventive maintenance requirements vary according to age, gender, basic education, occupation and operational mission. For example, in addition to the common preventive maintenance needs of all soldiers, such as proper nutrition and obtaining adequate sleep, soldiers in the XVIII Airborne Corps at Fort Bragg need emphasis on ergonomic and

physical training targeted toward preventing injuries associated with activities such as parachute jumping. On the other hand, soldiers in the 10th Mountain Division at Fort Drum require emphasis on achieving optimum performance in high altitudes and preventing cold weather injuries. In yet another setting, Army personnel working at the Pentagon need preventive maintenance programs designed to improve the health and fitness of soldiers who work long hours with very limited physical activity.

Some progress has been made in constructing wellness programs for elite troops, such as Navy SEALs and Army Special Forces. The Naval Special Warfare leadership formed a partnership with the Human Performance Laboratory at The Uniformed Services University of Health Sciences to develop clear, concise and authoritative guidance on physical fitness and nutrition. This guidance has been incorporated into the SEAL training at all levels. The program's success resulted in its adoption by some of the Army's Special Forces units, and it is currently being expanded for all Naval personnel.^{28,35} Some Army installations, such as Fort Lewis, Fort Carson and Carlisle Barracks, have tailored health and wellness programs to meet their units' specific needs; but they are in the minority. This concept must be expanded to cover all soldiers.

Developing Leaders Who Create, Monitor and Sustain an Environment that Values Health and Promotes Individual Health Readiness

General Shelton, present Chairman of the Joint Chiefs of Staff, recently wrote, “Our starting point is joint doctrine. Because doctrine undergirds everything we do, it is the logical beginning for our efforts to translate our vision of joint warfighting into reality.”⁵⁹ Force Health Protection doctrine is under development. A number of existing regulations, field manuals and training material address aspects of FHP and are included as citations in this paper. Some of them are currently under revision to reframe them in the FHP model and update language accordingly.

The goal of leader education, training, and development is to produce a corps of broadly-based professionals who are fully competent in technical, tactical, leadership, and training skills.⁶⁰ The Army blueprint for achieving these training goals is the TRADOC Common Core Course materials. The Common Core Courses are horizontally integrated into all officer, warrant and NCO training. They document training strategy, detail resident and unit training requirements, and serve as a professional development and continuing education system across the leader’s career course.⁶¹ There is recognition that FHP must become a mandatory component of all military training.

Basic trainees receive fundamental FHP education during Initial Entry Training (IET). “For many years, the Army has focused on soldiers performing tasks, but has missed the boat on the ethical and mental aspects of being a soldier.”⁶² The goal of IET is to produce motivated, disciplined, team-oriented soldiers who are physically and mentally prepared to meet the challenges of today’s Army. IET teaches each soldier to value mental, physical and spiritual health, and recognize its impact upon quality of life and unit readiness. Topics emphasized

include proper nutrition, adequate exercise, drug and tobacco abstinence, alcohol abuse prevention, stress management, regular health checkups, and spiritual and moral growth.

The IET Regulation identifies the need for cadre, NCO and officer development programs to emphasize the leader's role in establishing health-promoting behaviors.⁵⁶ It specifically delineates that the leader's role includes effective role modeling of good health and hygiene habits and demonstrated interest and concern for the soldier's health. The regulation recommends training with the following FHP doctrine: Individual Preventive Medicine Countermeasures (FM 21-10), Unit Preventive Countermeasures (FM 21-10), Inspection/Early Detection Techniques (FM 21-10), Healthy Life Style Habits (FM 21-20), Leadership Counseling (FM 22-101). Once the Army develops leaders who make Soldier PM a priority within their units, a health-promoting culture will evolve.

Conclusion

Military Health System leaders have recognized the importance of and designed programs to enhance soldiers' health readiness. Ultimately, though, ensuring individual health readiness is a command and unit leadership responsibility. Army-wide realization of this responsibility will require a change in leader attitudes toward FHP. The Army has many mechanisms for creating organizational change with the goal of improving readiness. In all cases, the foundation is the clear, authoritative doctrine that becomes the source material for formal military training. Thus, FHP doctrine must articulate the leader's role and responsibilities in establishing individual health readiness. Training must provide leaders with a FHP foundation; first, teaching them how to create environments that value health, and then, how to assess their soldiers' health readiness, implement programs for improvement, and measure their effectiveness. Leaders must make health a unit readiness priority.

Many pieces of FHP doctrine are currently in place at the Department of Defense and Army staff levels. Supporting policies and programs are beginning to emerge for implementation in military training and operational units. Additional recommendations that must be implemented to enhance FHP training include:

- ◆ Develop a “-10” Technical Manual for Soldier Preventive Maintenance as a command enhancement to support Putting Prevention Into Practice programs.
- ◆ Develop grade-appropriate FHP assessment, management and sustainment training for leaders and incorporate it into existing formal leader development programs.
- ◆ Develop a Unit Health Readiness report so that commanders can track health readiness.
- ◆ Conduct research and develop interventions to enhance individual health readiness among active and reserve forces.

Summary

As we prepare for the 21st century and the Army After Next, it is the leader's responsibility to ensure that soldiers are ready. In addition to developing advanced technology, the Army must give greater emphasis to individual health readiness. Throughout their careers, leaders must be trained to create, monitor and sustain environments that value and promote health.

ENDNOTES

1 David Jablonsky, "U.S. Military Doctrine and the Revolution in Military Affairs," *Parameters*, Autumn (1994): 18-36.

2 General Dennis J. Reimer, "Preparing Now To Meet 21st-Century Challenges. 1997 Army Green Book Article," *The Army Magazine*, October 1997.

3 Stephen E. Straus, "Commentary: Bridging the Gulf in War Syndromes," *The Lancet* 353, January 16, 1999: 162-3.

4 Food and Nutrition Board Committee on Military Nutrition Research, Institute of Medicine, *Assessing Readiness in Military Women*. (Washington, DC: National Academy Press, 1998), page 62, 64-68.

5 Unit readiness, a key component of force readiness, is the ability of a unit to deliver the output for which it was designed. Some aspects of unit readiness, such as the status of personnel and equipment, are quantitative and relatively straightforward to measure. But, the impact of qualitative factors such as morale, wellness and cohesion are much more difficult to assess because they are complex and, in some aspects, subjective in nature.

6 Force readiness is the Army's ability to man, equip, and train in peacetime, while concurrently planning to mobilize, deploy, and fight in war. Force readiness is difficult to quantify because it is dynamic in nature and includes many functions and is impacted by a multitude of factors.

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